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It was called the “mystery illness” and it was killing American Indians.

Within days of the onset of the flu-like symptoms, victims died from this disease that was, in late spring and early summer, confined almost entirely to Indian reservations in the Southwest.

Health officials were alarmed. Hordes of news reporters descended on the Navajo nation to cover this epidemic.

Why were the Indians dying?

Medical researchers were soon able to pinpoint the disease. It is caused by a hantavirus, contracted from inhaling particles of rodent droppings. By the waning days of summer, the disease had spread to other places, including Montana, where a Great Falls man who was not Indian died from it in mid-September. It was clearly striking more than the nation’s Indian population.

And so the attention directed at this “Indian epidemic” faded.

But Indians are still dying.

In Montana, Indians die prematurely at a rate almost twice that of the general population.

Death rates among Indians as a result of heart
MONTANA’S INDIANS

disease, cancer, accidents, cirrhosis, suicide and diabetes are higher for Indians than for other citizens of this state.

This terrible toll afflicts Native Americans from the moment of their birth. The state’s infant mortality rate for Indian babies is 43 percent higher than the rate for white children. The death rate for babies older than one month and younger than one year is 65 percent higher for Montana Indian infants than for babies born of other ancestry.

And the American Indian Health Care Association, which compiles these statistics, says the rates are probably underreported because a review of death certificates shows many Indians are not accurately identified as such.

Why does this health crisis exist? The reasons are as much social and economic as medical.

Montana Indians live in poverty at a rate three times that of their fellow residents. Half of those Indians who are poor are children and adolescents and they are more than three times more likely to come from homes where a mother is the only parent present.

Yet Indians get free health care, so why are they so sick?

Because, as the American Indian Health Care Association found, Indians face significant barriers to getting that health care. Only enrolled tribal members living on a reservation can get full health care benefits supplied by the federal government. And that health care is rationed.

Many Indians live long distances from Indian Health Service facilities. That becomes a factor when studies show that more than twice as many Montana Indians than white people have no access to a vehicle. And almost half the Indians in the state are without a telephone. A third of tribal and Indian Health Service facilities in Montana have no emergency and ambulance services, a critical need on Montana’s large and rural reservations.

In the face of these factors, honors students at the University of Montana School of Journalism decided to look into this health care crisis plaguing the state’s 48,000 American Indians. The stories these teams of reporters and photographers tell in the pages that follow are sometimes shocking and heart-rending. But some are told to reflect the pride that the state’s native population feels in the strides they are making to make themselves a better life, to reawaken the traditional beliefs that helped steel them to the trials of a culture turned upside down.

Montana’s American Indians are dying at an alarming rate.

But they are also learning new ways of living and rediscovering some of the old ways.

— Carol Van Valkenburg and Patty Reksten

THANKS

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This class was taught by Patty Reksten and Carol Van Valkenburg, both associate professors in the School of Journalism. Reksten directed the photojournalism students and designed the pages. Van Valkenburg guided the reporters and edited their work. They were assisted in teaching the class by Woody Kipp, the school’s American Indian affairs specialist who is also affiliated with UM’s Native American Studies Program.
He was told to look into trade school. But J. Michael Dempsey had his own agenda, one that included college, med school and returning to his reservation.

**DR. DEMPSEY: MODERN-DAY HEALER**

J. Michael Dempsey remembers how the words "trade school" shaped his life. Counselors at Gonzaga Prepatory School in Spokane urged students to go to college. In fact, post-graduation options other than college were rarely uttered at Gonzaga Prep, a place that didn't offer a single shop class.

But most of the kids in Dempsey's class weren't Indian and today Dr. Dempsey believes that for his counselor that made a world of difference.

"He told me to think about trade school because I wouldn't do good in college," the doctor says of his counselor, a priest at Gonzaga. "It was the same old story: Here I am, a poor Indian kid. You can't make it."

Dempsey, who is Salish and Sioux, leans back in his comfortable office chair and stretches like a cat coveting the sunlight as he recalls those days with a tinge of bitterness. He's snatching a rare break from the steady stream of patients he serves on the Flathead Indian Reservation.

And, as far away as overalls and machine shops are from the surgical "scrubs" that he wears now, Dempsey, a big, sometimes brooding man, still speaks cynically about the bum advice of a narrow-minded high school counselor that sent him on a roller-coaster ride to a successful private practice in Ronan — and a battle for Indian health empowerment.

"I was always taught to respect my elders," he says. "That guy hurt me. I believed him."

Dempsey went to college anyway, but not particularly because of the academic offerings. He won a football scholarship to the University of Idaho. Sports always came easy to him, so he planned to become a football coach and teacher.

But the words of that high school counselor still haunted him. He was convinced that the most he could accomplish at school was to knock helmets with gridiron opponents on the field and party away his nights. Thinking off the field didn't begin until the second half of school.

"I would sit and calculate what I needed," he says. "I would get a .9 and party like shit during the fall, then take easy courses in the winter and get a 3.3 or a 3.4." Just enough to get by, just enough to avoid trade school.

After nearly finishing his degree at Idaho, Dempsey walked away from school and took some odd jobs before enrolling at Whitworth College in Spokane, this time to become a nurse.

But before he left Moscow, he realized that maybe he wasn't as dumb as the priest had prophesied. He started attending classes. "I realized that if you go to classes, the tests are easy," he says. "I didn't have to steal tests anymore. I spent three-quarters of my life thinking that I couldn't do it because he told me I couldn't."

And he set out to prove to the world that he could; the words "trade school" began to drive him forward, not hold him back.

"I felt like I had to study an hour and a half for every hour my classmates studied," he says. "I always had to do better."

Dempsey, who was born in St. Ignatius and spent most of his summers there as a youth, moved back after completing his nursing degree at Whitworth in 1979. He worked briefly as a home health nurse for the tribe before being accepted for medical school at Michigan State University and serving his three years of residency at Sonoma County Hospital in California.

Now, five years of private practice later, Dempsey realizes that his drive to succeed had its price, especially for somebody who saw himself as "the kid from the other side of the tracks." Alcohol became his release, landing him in treatment three and a half years after opening his own practice.
"I tried harder, took on more than I could handle," Dempsey says.

Dempsey's life is still a blur of activity, though now he strives to balance work with family life. But the pressures of a medical practice are almost unrelenting. This spring morning he slipped out of bed at 5 a.m. for a date with a patient who dislocated his shoulder in a fight over a woman.

Breaks during his 90-hour work weeks are unusual. Even at home he's not off duty as he tells some patients to come to see him there. When he's not seeing patients, his time is spent battling "the bureaucracy" of the Indian Health Service and in meetings concerning the state of tribal health on the Flathead Indian Reservation.

And, while "the kid from the other side of the tracks" has proven himself in the western tradition, Dempsey still fights fiercely for the rights of his people. Now he wants the tribe to wake up to its power to heal itself. The Indian Health Service, the federal government agency dedicated to the tribe's health care, no longer serves his people, Dempsey says.

"It's sort of like the serfs going to the lord and saying, 'This is what we want to do. Can we do it?'" he says of the Indians' relationship with IHS. The agency — like Medicare, Medicaid and private insurance companies — is more concerned with keeping its costs down than improving the health of the patient, Dempsey charges.

American Indians make up about 60 percent of Dempsey's clientele, and he says the IHS may take up to 180 days to pay a bill.

"If your wages are out there in limbo ... that money is in their bank earning interest all that time," he says. "Meanwhile, I have to pay the bills with my own money."

Dempsey was born into a legacy of botched government policy toward his people that was passed down from his parents' generation. His father, a member of the Standing Rock Sioux tribe of South Dakota, was taken away from his family and sent to a Jesuit boarding school as a youth, and his mother, a Salish Indian, grew up on the Flathead during a time when the Bureau of Indian Affairs ran every facet of life.

"We had nothing going for us then," Dempsey remembers from his mother's description of the Ronan of her youth. "You had pain. You had open prejudice."

And he's doing everything he can to ensure that he doesn't allow that botched legacy to be passed to his own children.

At his prompting, the tribe has revived the possibility of taking over the job of IHS, accepting an allocation for health care directly from the government and administering it for itself.

"Nobody is going to take this tribe seriously until we take this over," Dempsey predicts.

He expects the plan to fall into place later this year. And by that time, he also expects to be working for the tribe or for St. Luke Community Hospital and Nursing Home, which is just across the street from his office.

He will trade control over his own operation, his own "destiny," as he puts it, for a cut in pay and a regular work schedule. The drive that once taunted him into achieving has been tempered with the desire to share his traditional culture with his three youngest children, Joshua, 12, Mariah, 11, and Amra, 9.

"I have worked 80-90 hours a week for five years," he says. "All I do is work. I live to work. By the time I'm ready to retire, I'll just keel over and die. I've come to realize that I've lost control."

"This culture has a good heart. I'd like to become more involved in more of the spiritual things. I'd like to do that with my family."

Dr. J. Michael Dempsey overcame the advice of one high school counselor 27 years ago, becoming the first medical doctor from his tribe. He wants others to know they can do what he did so he takes time to talk to groups of Indian youths about their future.

"Divorce yourself from people who tell you no," he stresses to the youngsters. "You can accomplish whatever you set out to do. I am a perfect example."

Dempsey hopes that his children will have a brighter future than he once thought he had.

Dempsey doesn't always check X-rays this way, but finds the sun a ready substitute, when asked to view them. Only a couple of times a month does he get to deliver babies, he says, but that's the best part about being a doctor.
J. Michael Dempsey is big medicine on the Flathead Indian Reservation. Some weeks he works more than 90 hours. But in spite of long hours he takes time to give his daughter Amra a few tips at her basketball game and even time for a ride with her in the shadow of the Mission Mountains.
Indians die at a greater rate than other Montanans from heart disease, cancer, accidents, cirrhosis, suicide and diabetes.

David Bell was a key player on his Harlem Wildcats basketball team. He knew he had a heart condition but he took medication and that controlled the problem, or so he thought.

**EARLY DEATH A WAY OF LIFE**

David Little Elk Bell's heart was both a blessing and a curse. Friends say he had a kind heart, filled with friendliness and a spirit of sharing that made the young Indian a popular youth on Montana's Fort Belknap Reservation. But his heart ultimately cost him his life at the age of 17.

Bell grew up at Fort Belknap, a 700,000-acre reserve on the plains of northcentral Montana. The reservation, about 40 miles south of the Canadian border, is home to the Assiniboine and Gros Ventre tribes. This is where the government dictated they would live forever, a guarantee first made in an 1855 treaty. In 1888 their holdings were whittled to near their present size, except for the final slice removed in 1896 when gold was discovered in the Little Rocky Mountains on the reservation's southern border.

Life is hard for many of the 3,000 tribal members. The poverty that comes from widespread unemployment is so familiar and of such duration that most have learned to cope. But the kind of pain that isn't transitory and sometimes seems impossible to quell comes from the tragedies that snuff out the lives of so many young Indians.

Montana Indians die at a rate that is 60 percent greater than the mortality rate for the general population.

Figures from the Indian Health Service, adjusted for differences in age distribution among the two populations, show that Indians die at a greater rate than other Montanans from heart disease, cancer, accidents, cirrhosis, suicide and diabetes. Only in the category of stroke do Native Americans in the state have a lower death rate.

So Bell's family, like so many others in the Indian community, is not unique. They have been rent by the suffering that comes when life is lost early and unexpectedly.

Bell's life was unsettled almost from the start. At nine months of age, his father, Billy, was killed in a shootout. His mother left the reservation for Nebraska and Bell's grandparents, Preston and Sina Bell, became the only parents he'd ever know. They raised him as their own child, just as they did another granddaughter, Jackie. The older Bell children still at home — aunts and uncles — became sisters and brothers.

He was a "delicate-type kid, physically and mentally, and we had to be sensitive to his needs," recalls Jim Bell, an uncle. He had to toe the line just as the other youngsters did, Bell says, but a gentler form of punishment was used to keep him in line.

David Bell didn't need much disciplining once his life became consumed with thoughts of basketball. He'd play incessantly in the daylight and dream of it at night. But when Bell was not yet in his teens he began to have chest pains. He took medication for what doctors discovered was a heart condition, and Sina Bell says problems never slowed him down, especially in basketball. He played all-out, she says, and never wanted to sit out even for a rest.

Bell says she wasn't greatly concerned about his health because in 1991 a heart specialist in Great Falls said his health was strong enough to allow him to join the Army once he graduated from high school.

David Bell's aunt, Dodie First Raised, says neither the doctors at the Indian Health Service Hospital nor the specialists in the city realized the seriousness of his heart ailment.

Basketball in small Montana towns is a serious undertaking, and nowhere is it taken more seriously than on the state's Indian reservations. This year was shaping up as a good one for the Harlem Wildcats and the sense of pride the reservation residents felt last winter was almost palpable.

Bell's dreams were also taking shape, as he was a key player on the team.
David's death came as a big blow to his teammates Tom Champagne, Ted Brockie and Joe Addy. The words on Brockie's shirt are from a song heard after Bell's death. During a basketball tournament on the Fort Peck Reservation, his jersey number, 24, and his name were displayed on people's faces, their clothes and on signs.

A Health CRISIS

...FOR SOME

The Wildcats were battling for supremacy in the tough Class B eastern district. On Jan. 23 an overtime defeat of rival Poplar, from the Fort Peck Reservation, made the team euphoric, Bell's backcourt mate, Adrian Main, recalls. "No one would've stopped us. That game rocketed us to a higher level," he says.

After a customary post-game team feed with Wildcat fans, Main gave Bell a ride home. Main says Bell was happy, and as he bid Main goodbye, flashed him a proud look. "I'll always remember that look," Main says. "His eyes said we're number one."

Bell watched TV awhile and went to bed about 1 a.m. When Sina Bell retired minutes later she heard odd noises in her grandson's bedroom and hurried to find out what it was. "He was blue. He was moving a little bit," she says, "but he was dying."

An ambulance was summoned, but neither emergency crews nor physicians at the hospital could revive him.

Sina Bell says she blames no one for her grandson's death, but can't yet imagine how she'll ever adjust.

"I watch for Dave to come in that door all the time," she says. "But I guess it was meant to be."

A few months after his nephew's death, Jim Bell reflects on the tragedy that strikes so many Indian families.

"It's a shame his dad was taken away from us so young and now the same thing has happened to Dave," he says. "It's hard to understand, but you got to live with it. There's no other option."

Each member of David Bell's team gave a rose to David's grandmother Sina Bell in a ceremony honoring his memory. Cory Engle gives her a hug as he presents her with his rose. At her home is an honor basket that contains his jersey, flowers, pine cones and a figurine of Michael Jordan, who also wore the number 24. His basketball shoes, food and other gifts are left on his grave.

Text by Bernie Azure
Photos by Jerry Redfern
Northern Cheyenne have held sweats for centuries as a way of mending their lives.

**HEALING THE SPIRIT**

For Indian males in Montana, suicide is the fourth leading cause of death.

The heat is stifling; it smotheres while it soothes. A slight flicker of light glowing from the rocks in the center of the sweat lodge illuminates the steamy air.

One by one, the prayers of each participant boom into the confines of this tent-sized hut. The sound reverberates with a power that almost chills each burning bone. In cramped quarters, it's a ritual of sweating together and praying together. Most of all, it's healing together.

The Northern Cheyenne Indians have practiced their sweats for centuries as a means of mending their lives. It instills a sense of unity among those who partake, a unity that some of the elders worry is on the verge of extinction.

Years ago, when the only education for reservation kids was a white boarding school, the youth learned quickly that their native tongue and traditional ceremonies weren't right. They were nothing but "dumb old Indians" unless they adapted to the white world.

Faced with such stigmas, Indian parents didn't teach traditional ways.

John Paul Flying, a mental health technician at the Lame Deer health service, says Indian youth are caught between two cultures: the white culture that was forced upon their ancestors and remnants of a native culture white society tried to squelch. Few Cheyenne remain, he says, who thoroughly know and understand the traditional culture.

Flying says it is too late to cure the tribe of a leprous force that spread long ago. But he's trying his damnedest to save a struggling youth.

It's a pressing problem. The suicide rate for Native Americans in a region that includes all of Montana, plus Wyoming's Wind River Reservation, is the second highest of any of the 12 Indian Health Service regions. The rate for the last year in which statistics are available is nearly 31 deaths per 100,000. The rate for all races in the country is just under 12 per 100,000.

For Indian males in Montana, suicide is the fourth leading cause of death.

Faced with such grim statistics, tribal members like Lee Lonebear are hoping to stop the suicide epidemic by helping teach struggling youngsters the ways of their ancestors. In the past, Lonebear explains, sacred ceremonies were enough to keep the tribe on track. Nowadays, traditions such as the sweat must be retaught and relearned.

"It's just starting to pick back up, because the government just allowed it," he says.

The sweat empowers teens to turn away from drugs and alcohol, Lonebear says.

"I don't explain what I do," he says. "I can't." However, "it seems to work. Some get stronger with prayer. I tell them it's hard here. Keep doing good, just to walk away. They come..."
The suicide rate for Native Americans in a region that includes all of Montana, plus Wyoming's Wind River Reservation, is the second highest of any of the 12 Indian Health Service regions. The rate for the last year in which statistics are available is nearly 31 deaths per 100,000. The rate for all races in the country is just under 12 per 100,000.

Capt. Wayne Headswift, BIA official, says that now many suicide patients are not being jailed, but are sent to clinics to get help. Nearly 75 percent of Indian suicide attempts are alcohol-related.

Text by Karen Coates
Photos by John Youngbear
Jay was fine. 28-year-old Blackfeet mother that 2-month-old Alton cheeked. Yet as she stood bathing him, that evening (SIDS). check on Alton. She found him cold and still, and uneasy. This night when she laid him in his crib, frequent spitting up of his formula made her feel instead of his usual wails of protest, she heard only. When infants are asleep, SIDS is the sudden, is highest among Northern Plains Indians. The cause of death: sudden infant death syndrome (SIDS). Called crib death in the past because it strikes when infants are asleep, SIDS is the sudden, unexplained death of a seemingly healthy infant. Doctors do not know its cause nor how to prevent it, though they have identified factors, such as second-hand cigarette smoke and low-birth weight, that increase the risk. It is the leading cause of death of infants aged one week to one year, and its incidence rate is probably higher, since a recent analysis of infant death records show 35 percent of Indian infant deaths were incorrectly classified as non-Indian. The sudden, shattering death of their baby left the couple reeling with grief and guilt and groping for ourselves. For families pulled apart by this tragedy, the pain seems insurmountable. Sudden Infant Death Syndrome, the leading cause of death for all infants aged one week to one year, is devastating to families. But Plains Indians have the highest rate of any population. They sought solace in alcohol. For Aimsback, it took a stay in a treatment center to help him face his grief and begin putting his life back together. For James, it was returning to her work as a Head Start teacher in Browning that kept her from going crazy. Teaching and nurturing a roomful of irritable preschoolers left less time for the pain. Having a baby also helped. George Jr. was born a year ago. "George hardly lets him out of his sight," James says. "He just treasures that little guy." When we brought him home he made it very clear that our baby wasn't going to be sleeping in a bassinet or crib. He was going to sleep with us." When Alton died, the reservation community reached out in sympathy. Among those who contacted the family was Delia Blackman, a secretary at Browning's high school. She gave the couple information about SIDS, information Blackman had discovered after SIDS had struck her own life two years before. At age 21, on a chilly March day, Blackman watched the burial of her first born, 6-month-old Jessica. With her husband Ronnie, family and friends, she released a balloon to the sky along with a prayer: "Fly free like a bird, honey, I love you," she whispered. "Please God, give me a sign. I need to know that she's OK." Jessica had been a big baby, alert and, except for a bout with pneumonia at five months, healthy. Just two days before her death, the doctor had checked the infant and found her lungs clear. The Blackmans had gone out to a dance and left Jessica at a babysitter's for the night. In the morning, Blackman awoke to a pounding on her door and the news: The babysitter had checked Jessica at 7 a.m. and found her sleeping. Fifteen minutes later the woman's daughter had found the child dead. The diagnosis: SIDS. "Maybe if I hadn't gone out that night, maybe God wouldn't have taken her," Blackman says. "I blamed my husband, I blamed me; there is still a lot of blame with it is what helped me get through the grieving process," Blackman explains. It wasn't until the couple sought help in a treatment center for substance abuse that Blackman says she "began realizing she was really gone. It was hard because it was like it happened yesterday." She and another woman started a grief support group in Browning, Compassionate Friends. "I found out, hey, you're not alone in this world. This has happened to other people. Going to those meetings and dealing with it and helping others deal with it is what helped me get through the grieving process," Blackman says. Having another baby also helped, although the couple's joy at the birth of Douglas, now 3, was edged with fear. Blackman would set an alarm clock and check on the infant hourly through the night. Finally, they brought the child into their bed, where he still sleeps. "He has to be right next to me so I can know he's breathing," Blackman says. For both couples the grief is still palpable. "It comes back and sits on my shoulder," Blackman says. But she believes she got the sign she had prayed for at Jessica's funeral. On their way to Billings, the following day, the couple and Ronnie Blackman's brother Doug saw something that astounded them: "It was snowing," Blackman recalls. "You wouldn't think birds would be out that time of year. I'm not kidding you, this big bird, it come down, and it was flying with us, and it was flapping its wings looking at us. I could've unrolled my window and touched it. I get chills just thinking about it. Oh, it was beautiful; I never seen nothing more beautiful in my life. It had rainbow colors on its neck." "We were going around a bend and Doug says, 'Oh no! It's gonna get hit!' And as soon as that car come that bird just went up. And we stopped and all I could think of was, 'That's my baby! Stop! I want to go see her. I want to catch that bird!' We turned around but we couldn't find her." Back home, while going through sympathy cards, they came across several feathers sent with the cards. For Blackman, it was a sign her baby was OK. "To this day, whenever I'm thinking about Jessie I run across a feather. I've got so many feathers laying at home, just laying around, or taped on the wall, or pinned by her picture."
In Montana, SIDS claims five out of every 1,000 Indian babies — three times the rate for whites. The American Indian Health Care Association suggests the rate is probably higher, since a recent analysis of infant death records shows 35 percent of Indian infant deaths were incorrectly classified as non-Indian.

Text by Elizabeth Ichizawa
Photos by Jay Schweitzer
Taking care of a baby is a big responsibility for anyone. But Kristal Davis, who was pregnant at 15, has managed to continue to be a top student and a mother.

**TRIALS OF A TEENAGE MOM**

It's 7 a.m. on a school day and Kristal Davis has to get up. Above her bed hang heavy-metal posters and a picture of a unicorn. A stereo and rock albums sit in a corner, photos of friends adorn the mirror, and athletic and academic awards decorate the walls. It is a typical teenager's room, except for one thing: the squirming little body curled next to Kristal's slender one.

Kristal and her 15-month-old son, Chad, are about to start their day.

For Kristal, who lives with her mother, brother and son in Heart Butte on the Blackfeet Reservation, it will be a full and carefully organized one. She will get Chad and herself dressed and fed, then drop the boy at his great-grandmother's on her way to school. In the afternoon there might be basketball or cross-country practice, and in the evening a 32-mile drive into Browning for training as a substance abuse peer counselor. In between she will tend Chad, grab time with her boyfriend, Chad's father, Steve Bull Child, and work on maintaining straight A grades.

For Chad, a sturdy and confident toddler, the day will be filled with the people who make up his world. Mummy, of course, but also Grandma and Great-grandma, who help take care of him, assorted friends and relatives of Kristal's, and Daddy, who plays with him in the evening.

Kristal is, as school counselor Jack Edmo says, "an exceptional young woman," but her ability as a super-mom to juggle academics, athletics and motherhood owes much to the traditional Native American extended family, where children are welcomed and valued, whatever the circumstances of their birth.

Heart Butte is a cluster of low wooden houses, dwarfed by the prairie and the awesome peaks of the Rocky Mountain Front. Its one large building is Heart Butte School, a place where Kristal's situation is not unique.

The birth rate among high school-aged Indian
women in Montana is more than three times greater than the rate for all other women aged 15 to 19. And in 1990, the American Indian Health Care Association reports, more than one of every three Indian women aged 18 or 19 gave birth.

At Heart Butte School, four of the students are mothers. Nine women have become mothers in the four years since the school was built, and all have stayed in school. "We make every effort to keep the girls in school," says school nurse Mary Louise Little Dog. "All our girls are fully integrated. I tell them, 'You may have a baby, but don't forget your education.'" On the Blackfeet Reservation, where 15 percent of all mothers are 18 or younger, there is little stigma attached to being young, unwed and pregnant. "People are pretty relaxed about it," Little Dog says, adding that it's not unusual to see teen fathers holding their babies at basketball games. "The fathers will watch the baby, they'll change them. It brings out a tender side of the boy," she says.

Fatherhood brought out that side of Bull Child, a quiet young man, wary of strangers. The tall, lean youth is a versatile athlete. With Chad, he is gentle and sure-handed and the boy adores him. Kristal's pregnancy at 15 was traumatic for everyone. Although she had been friends with Bull Child since she was a 13-year-old shooting baskets with the boys, she was scared to tell him. "Most boys (will) say it's not mine," she says. Bull Child's reaction was a mixture of shock, dismay and pride. Kristal's mother, on the other hand, "hit the roof," as Little Dog recalls. "Her mom was really hurt because she had all these plans for Kristal."

The nurse, whom the students call "Aunti," sat Kristal down to discuss the options: abortion, adoption, or motherhood. Despite urging from Davis to terminate the pregnancy, Kristal and Bull Child decided to keep the baby. It is a decision most pregnant reservation girls make. According to Blackfeet Special Services coordinator Francis Onstad, who says placing children for adoption is rare and abortion "is almost unheard of here." Little Dog says she knows of girls who have had abortions but discourages it because she believes it extracts an emotional toll. "Next year, in five years or 20 years, it might come back to haunt you," she tells the students.

She and Onstad agree that families nearly always welcome the infants. "They're really good about that. They might not have a lot but they have love," she says.

Jack Edmo agrees. "Families on the reservation are really supportive of young parents. When a girl becomes pregnant there is a lot of stress but afterwards everyone really welcomes it and tries to help their young couple raise the child."

Onstad, who coordinates teen parenting classes in Browning, says too often young girls who become pregnant drop out of school and go on welfare. "This leads to a cycle of poverty," she says. In Heart Butte, however, teachers, counselors and the nurse work with teen moms so they can complete their education. Kristal went through pregnancy, birth and post-partum without missing a beat in her schoolwork.

Little Dog and Kristal's obstetrical practitioner also monitored the teenager's pregnancy, since very young mothers are at risk of complications, including low birth weight. A 1993 study by the American Indian Health Care Association shows that complications from pregnancy and childbirth are the leading cause of hospitalizations among Montana Indians.

During Kristal's labor, which was attended by her mother, her running coach and a family friend, Karen Davis' anger evaporated, and today she dotes on her grandson. "Now I wouldn't change it for the world," she says.

Kristal expects to be valedictorian of her class, and plans to attend Montana State University, as does Bull Child. "Kristal has a lot of dreams and she is planning to go after them. She knows education is the name of the game," says Edmo.

But it's hard. She no longer has much time for friends or rock music, and when Chad wants Mummy, and Mummy has been on the go for 14 hours and still has to study for a French test, it is hard indeed.

As for regrets, they are not apparent when she grins at her bright-eyed boy. "It's worth it," she says.

The birth rate among high school-aged Indian women in Montana is more than three times greater than the rate for all other women aged 15 to 19. And in 1990, the American Indian Health Care Association reports, more than one of every three Indian women aged 18 or 19 gave birth.
Steve Bull Child comes over to see Chad when he can, but wishes he could see even more of him. After Bull Child leaves, Kristal puts Chad to bed. He usually falls asleep at around 10 p.m. allowing Kristal to catch up on her reading for school.
Two members of the group died this year. Others say their stomachs ache most of the time. But addictive habits are hard to break.

THE LYSOL GANG

It’s been months since Beatrice died with the tangy taste of Lysol on her lips. But her death hasn’t stopped the “gang” in Lame Deer on the Northern Cheyenne Reservation from indulging in the fatal flavors of the common household disinfectant.

The shack where they spend their days is still home for a couple in the group. Inside, the putrid stench of Lysol and urine is almost overpowering. Rain seeps through the roof and trickles onto a crumbling wooden floor. In what once was a bathroom, a bucket serves as a toilet, almost lost amid a foot-high pile of empty Lysol cans.

Five of them wait in their hangout for the mixed blessing of another deadly can, or the money with which to pay off a bootlegger. They beg and plead for a few spare coins. They need another swallow.

Most everyone on the reservation can identify the 20 or so members of the “Lysol gang.” They’re seen walking the streets daily, looking for an odd job or a willing seller who will sustain them for a while. They’re the butt of many jokes told by those who know them only from afar.

But one whiff of their breath will convince you their habit is nothing to laugh about. This furniture-less abode has been Margaret’s and Howard’s home for the past 21 years, the place where their friends join them to partake in their flirtation with death.

The addictive habit lured them at least a decade ago. They know they are wide open to cirrhosis — or even worse. They say their stomachs ache intensely if not filled with the proper portions of food to go with their drink. It’s killing them just like it snuffed the life right out of Beatrice. Just ask Michael about his wife’s death.
He says he started drinking 18 years ago when he and Beatrice married. This was back in the day when most drinkers on the dry reservation relied on bootleggers to supply them with booze.

But soon the price became exorbitant for the unemployed and underpaid. Somebody figured out that Lysol contains 79 percent alcohol—it doesn't take long to get drunk with percentages like that. All it takes is a nail to poke a hole in the top of the can and a milk jug in which to mix their concoction—one can of Lysol cut with half jug of water.

"That's about the cheapest drink we'll get," Joe explains. That's so despite the black market price of $7 a can. Bootleggers haul Lysol back from Billings by the case—Lame Deer stores won't sell it any more—and jack up the price from $4.89 a can. But 79 percent alcohol at 7 bucks a can is better than 12 percent alcohol in a $5 bottle of wine. The ritual begins. The five drinkers pass the jug among them, getting drunk on just a few swallows.

"I drink Lysol, hair spray, even mouthwash and Listerine," Margaret says with a hint of pride.

But Gerald explains that aerosol hair spray isn't what they prefer, in part because it contains only about 40 percent alcohol. Their biggest worry is that hair-spray makes them burp. If they're smoking and they burp, their breath can ignite their faces. Several reservation residents tell home stories about a time a few years back when some hair-spray drinkers were horribly burned.

Colleen, who died this summer from acute drug and alcohol overdose, talked last spring about the roots of her habit. Almost 12 years ago, her daughter was taken away, she said, although she never explained why. She only said again and again: "I was alone, lonesome." She'd been drinking ever since. "I just started boozing. I just let everything go."

For 22 years some members of the "Lysol Gang" have been getting drunk by using a mixture of Lysol disinfectant spray and water.
Colleen said she started “boozing” after her daughter was taken away. “I was alone, lonesome,” she said. She knew her habit could cost her her life, but she couldn’t seem to stop. Colleen died this summer of acute drug and alcohol poisoning.

But the momentary happiness vanishes when the hypnotic effects of the alcohol dissipate. “Once it wears off—start thinkin’ about her again.” By now the tears stream down his face.

So Michael continues his routine, despite his wife’s warnings that he, too, would end up in his deathbed. “Michael, don’t leave me.” That’s what she told me. “Please, Mike, stop.” But I can’t,” he says. “Pretty hard.”

“This is something about drinkin’. Once you start drinkin’, you can’t quit.”

This is why most of the Lysol drinkers have had an ongoing acquaintance with treatment programs, the health clinic and even jail. Dr. Jon Hauxwell of the Lame Deer clinic says many of the gang members go through the tribal alcohol program at some point. Some end up in the emergency room with ulcers or cirrhosis of the liver.

Hauxwell says the effects of drinking Lysol are practically identical to the results of drinking alcohol of the same intensity in any other form. Lysol includes phenol, which is a mild antiseptic used in throat medications, but he says it has no alarming effects on one’s innards. Stomach pain is the only intensified symptom he can identify.

“They seem more prone to stomach aches — alcoholic gastritis,” he says. “Most of these Lysol drinkers are tough as nails. They hang on for a long time.”

So in between bouts of malady, members of the Lysol gang go right on doing their thing. Occasionally, the Lame Deer police pick them up on intoxication charges if they leave the comfort of their hideout while on a binge. Capt. Wayne Headswift says, “If they stay in there, then we don’t get calls on them.” The police only interfere with the bunch if they cause a commotion in public, he says.

Sometimes the intoxicated simulate severe stomach pain to get out of jail. Headswift says, “If they stay in there, then we don’t get calls on them.” The police only interfere with the bunch if they cause a commotion in public, he says.

Headswift says the law doesn’t differentiate between one form of alcohol or another. Intoxication is illegal, and punishable by up to 72 hours in jail and a $20 fine, regardless.

“It’s pretty hard to distinguish whether they’re drinking wine, beer or the mixture,” Headswift says. “If they’re drunk, they’re drunk.”

And habitual offenders are urged to seek rehabilitation. Force won’t work, Headswift says, because a patient must be willing in order for treatment to be successful. Most only think far enough ahead to visualize their next drink. The cycle continues.

Headswift says tribal officials are working to erect greater legal barriers to the Lysol sales. “It’s not an offense to sell Lysol, but it’s an offense to sell an alcoholic beverage,” he says.

Yet the cleansing agent can be found nowhere on the shelves in Lame Deer. Roberta Roth, the manager of the IGA store, says she removed Lysol from the store’s inventory about five years ago after several near-violent episodes with the drinkers in her store.

“There’s something in that stuff that makes them really hard to handle,” she says. “When they’re on it, they come in and demand it, and they get pretty nasty.”

IGA also keeps all aerosol hair spray behind the counter, and only women can purchase it. “We don’t sell hair spray to men,” Roth says. “We don’t have to sell anything to anybody.” But even all the precautions aren’t enough protection from an adamant drinker. Roth recalls the time when “a little old lady” slugged her for denying her the can of hair spray that could cure a hangover.

Roth says she’s sure the gang is beyond hope for reform. It’s the kids she worries about most.

“I’ve seen 7 and 8-year-olds taking care of little babies, and that’s no life for children,” she says.

Meanwhile, Colleen continued to stare out the dusty window pane, that old familiar odor emanating from her breath. She knew Tara, her teen-age daughter, at home across the street, wondered whether she’d ever stop. She knew Tara wanted a mother, not a ghost from a grave.

For a split second, Colleen’s eyes glistened as though a tear or two were welling up. Or maybe it was just the pungent air.

She grabbed the jug and took a gulp, and a tinge of Lysol dribbled down her chin.
Josephine Steele, a 74-year-old mother of 11 who has diabetes, stretches before a workout as a member of the Blood Sugar, Sweat & Tears Exercise Club.

Some call diabetes the “Indian disease” because it is so prevalent among the Indian population

'BLOOD SUGAR, SWEAT AND TEARS'

Beads of perspiration glisten on Josephine Steele's forehead as she sinks slowly onto the carpeted floor in the exercise room of the St. Ignatius Tribal Health Center.

Sitting cross-legged, she presses her lips together, her brow furrowed as she raises an arm above her head. Her neatly styled grey hair stays in place even as she stretches.

This 74-year-old mother of 11 and grandmother of 27 wasn't able to do much of anything when she started the “Blood Sugar, Sweat & Tears Exercise Club” program in January.

"I was pitiful," Steele said wryly. "I never did sweat because I never did that much."

But Steele has been meeting with 11 other seniors three times a week to improve her fitness level. This club on the Flathead Indian Reservation is bound together by more than exercise. All members including the instructor have diabetes, an affliction that keeps the body from handling moderate sugar intake in a normal way.

People with Type II or non-insulin-dependent diabetes mellitus can control its effects with diet and exercise.

Long-term complications from diabetes include kidney failure, eye problems, and blood vessel and nerve damage and ultimately amputations.

This has been called the "Indian disease," says Larry Pitts, fitness wellness coordinator for the tribal center, because of its high incidence among Native Americans.

Indian Health Service statistics record about 1,500 people on the seven Montana reservations have diagnosed diabetes.

According to a 1986 study done on the prevalence of diabetes on Montana reservations, Indians were diagnosed with diabetes at a rate 3.6 times greater than the rate for the rest of the U.S. population. Indians die from complications of diabetes at a rate nearly double that of the rest of the population.

The Flathead Reservation, where St. Ignatius is located, has about 200 diabetics.

Before 1940 diabetes was so rare among Indians that the federal government offered a prize to the reservation that could produce one diabetic, says Thomas "Bearhead" Swaney, department head of tribal services on the Flathead Reservation.

A big factor is the change in lifestyle, says Swaney. Traditionally, Native Americans were hunters and gatherers and ate foods high in protein and carbohydrates. They got their exercise by running, riding horses and hunting. Now they lead a much less active lifestyle.

Steele concurs with that assessment. "I was a couch potato," she admits.

A staple of many reservation diets are federal subsidies that include foods loaded with fat and salt. And tradition has taken a back seat to watching TV, riding in cars and eating fatty foods.

"I jokingly say that macaroni has replaced bitterroot as the cultural food," Swaney says.

But that doesn't fully explain the higher prevalence of diabetes in Native Americans. One theory relates this to a "thrifty" gene, which Native Americans may have developed to adapt to their "feast and famine" lifestyle. Food was sometimes scarce so over the years their bodies developed a way to store food as fat.

When they didn't have food, the fat was then released as energy to ward off starvation.

However, while their lifestyle changed and they no longer needed to conserve that food as fat, the "thrifty" gene remained. The foods Native Americans eat are still being stored efficiently, but the higher fat content causes the people to gain a lot of weight. That creates an overfed but malnourished people.

Don Scarborough, public health nutritionist for the Indian Health Service on the Flathead Reservation, says there are no simple cures. When he sees patients for the first time, he asks about their goals and their plans to achieve them. If patients want to lose weight, for example, Scarborough probes a bit to find whether their plan is realistic.

"Ninety-five percent of all weight-loss efforts fail," Scarborough says. "Changing a person's eating habits is harder than changing a person's religion."

Although the ultimate goal for health care providers is to see the reservations diabetes-free, they are realistic and look for small changes that can make a long-term difference.

Scarborough says the way information is presented is important. Seeing they don't have to
take drastic measures that seem impossible to attain makes people more willing to make changes.

The goal of the program is "to improve the overall ability to do day-to-day tasks," Scarborough says.

Steele is an excellent example of a person for whom small change makes a big difference. Early this year she was barely able to get into and out of the van that picks her up in Arlee, a small town 18 miles south of St. Ignatius. Pitts remembers when she limped painfully down the hallway and her feet kept slipping off the pedals on the exercise cycle. Three months later she races others into the building to start her routine.

Steele admits that when she was diagnosed with diabetes more than 20 years ago, she was told she needed to exercise more but was not inclined to start by herself.

But when she heard about the exercise program in St. Ignatius this year, she decided to join. Now, every Monday, Wednesday and Friday, a van from the center picks up Steele and four other seniors in Arlee for the one-hour session. She admits that she likely wouldn't exercise if she was not part of the "Blood, Sweat & Tears" group.

There is an obvious affection between the exercise coordinators and the group. They exchange good-natured insults as each member steps up to a blood monitoring machine and places a drop of blood on the sensitive strip. A number lower than 200 is considered good. This day, Steele's number is 97. When she checks it after exercise, it will have dropped to 78.

"They can drop 100 points just from exercise," said Lynn Hendrickson, Pitts' work partner.

With regular exercise and a modified diet, diabetics can gradually decrease the amount of insulin or medication they use. Because of this they're not so dependent on the insulin.

As the group begins to exercise, Pitts hollers words that both challenge and encourage.

"Neuropathy," Pitts shouts. "Big word. Lot of pain." He's referring to one of the painful complications of diabetes, a decrease in nerve function. Neuropathy causes diabetics to lose feeling in their legs and injuries may go unnoticed. Meanwhile, the flesh around the wound gets infected and causes the tissue to die. If left untreated a limb may have to be amputated.

Barb Durglo, a diabetes certified specialist, lists some injuries she has seen because of neuropathy. She tells of a diabetic who had visited a sweat lodge and stepped on some hot stones in the tipi. Because he had no feeling in his feet, he was severely burned.

The Flathead was the only "amputation-free" reservation in Montana last year. Durglo attributes that to the tribes' monthly foot-care clinics. She estimates diabetes education has saved the health system $10 million a year because of fewer complications.

"They can drop 100 points just from exercise," said Lynn Hendrickson, Pitts' work partner.

As they settle down to eat and visit with their friends, a couple of details in their conversation set these people apart from just another small-town couple. They discuss the weather and blood sugar levels. And Steele reminds her husband to stop at the pharmacy on their way home to pick up a box of 100 syringes and needles for her insulin injections.

At Fort Peck, battling diabetes

For 10 years, June Clark nursed her mother. And every day of that 10 years she watched her mother suffer from diabetes, a disease that is rampant on Montana's Fort Peck Reservation.

Even now, more than a year after her mother's death, as she enters the room where her mother underwent kidney dialysis, Clark averts her eyes from the chair where her mother sat, prisoner of the machine that gave her life.

As they settle down to eat and visit with their friends, a couple of details in their conversation set these people apart from just another small-town couple. They discuss the weather and blood sugar levels.
When Buzz Momberg was diagnosed with colon cancer he sought a cure in both the Indian and the white world

MELDING TECHNOLOGY WITH TRADITION

Buzz Momberg had visited the Indian Health Service in Browning a few times, complaining about the stomach pain that never seemed to let up much. One day when the nagging ache became a gnawing torment, he showed up at the Blackfeet Community Hospital emergency room. Doctors there sent him to Great Falls to be examined by a specialist.

Days later a surgeon removed a malignant tumor that had blocked his colon. The prognosis wasn't good.

Momberg's life changed after that, both physically and mentally. The 42-year-old underwent seven months of chemotherapy, eventually losing his hair. But he also began to take herbal medicine to help kill a disease his ancestors had not experienced, with remedies they relied on for any ill they faced.

Momberg also quit his job as an in-patient alcohol and drug counselor in Browning. He moved to Heart Butte, a place he considers a center of renewed Blackfeet spirituality, so that he could concentrate on balancing the physical, mental, emotional and spiritual aspects of his life, according to traditional Blackfeet beliefs.

And he knew he would beat the cancer.

"If I didn't have that traditional thought pattern, I probably wouldn't have been able to deal with that," Momberg says, a little more than a year after his last chemotherapy treatment. "I'm one of the few survivors of cancer on the reservation."

Cases like Momberg's, in which American Indians use a combination of modern medical technology and the traditional root medicines and spirituality to deal with illness are more and more common, says Gerald George "G.G." Kipp, a spiritual leader on the Blackfeet Reservation. After years of government-driven ethnocide, he says, Indians and even some doctors are beginning to see the value of traditional spirituality in the healing process.

The killing of the Indian culture has continued from the days of the boarding schools and the "John Wayne" type western movies in which the Indian was either the enemy or the butt of the jokes, says Kipp. The Indian, he says, was not viewed as human.

"We are no longer considered the enemy," he says, comparing America's past view of Indians to its view of the Vietnamese during the War in Vietnam. "The Indian has been perceived as a person."

Kipp, who is also the director of vocational/technical education at Blackfeet Community College in Browning, shares the responsibility with his wife, Melinda, of being a caretaker of one of the tribe's last remaining medicine bundles. Bundles contain objects considered sacred by the Indians and are opened only at specified times of the year as part of sacred ceremonies. Bundles permit direct communication between God and man, Kipp says, and they hold the power to heal mentally, physically and emotionally. Belief in this traditional culture was nearly stamped out by a society that did not attempt to understand its value, he says.

But that acceptance of traditional healing is changing with the likes of Mary
Ellen LaFromboise, the service unit director of the Indian Health Service's Blackfeet Community Hospital, grew up on the reservation and says the facility is trying to combine the two worlds, but that it will take time to find a balance.

"At this time, we have not reached a comfortable way of blending the two at this facility," she says, but adds that plans are in the offing to pitch a tepee outside the hospital for specific healing ceremonies.

One of the problems, she says, is the personal nature of the care healers like Kipp give, partially due to how the old ways have been perceived.

"It's not something that somebody is just going to talk to you about," she says. "It has been laughed at and scoffed at in the past."

Yet while ridicule plays a role in why some Native Americans shy away from talking about traditional healing, even among themselves there are things that are not discussed.

Momberg got his herbal medicines from what he says is a society of elder Indian women in Canada. He has no idea what herbs and roots comprise his medicine. He just calls them gifts from God.

"I don't ask them what it was," he says. "That was given to them. It's not my place to ask." Dr. Richard Odegaard, who has been at the Blackfeet Community Hospital for seven years, says he encourages patients inclined to go through traditional ceremonies to do so because of the psychological benefits they reap.

"It works very well for some patients," he says. "There have been a couple of cases where it has worked better."

"Doing what you believe in tends to work," but not everybody on the reservation believes in the healing powers of the traditional Blackfeet culture. "That's a thing of the past. That's gone," says Melvin Running Wolf, 67. "Not everybody can do it."

A product of a boarding-school education at Heart Butte, Running Wolf received training as a medic in World War II and returned to serve as the lone attendant in the old hospital's emergency room. He worked the 3:30 p.m. to midnight shift for more than 30 years. The new structure, built in 1985, even has a room named after him.

Running Wolf says with obvious pride that he is a full-blooded Blackfeet, but in the same breath declares the old ways dead. He is fluent in Blackfeet, and served as an interpreter for the old people who came to the hospital but could not speak the language of the white doctors.

The elders did not come into the hospital as much as people do now, he says, partially because of the home remedies, herbs and rituals that they practiced. Running Wolf can recall his own parents giving him such "home remedies" as a child.

"Most of our medicine originated from herbs," he says.

But the traditional healing that Kipp is trying to revive is not the same as those home remedies of the past, Running Wolf says. He charges that Kipp, and others at the forefront of the Native American revival, talk about what they do too much to be bona fide.

"Not just anybody can do it," Running Wolf says. "The new healers, they kinda like to advertise that they can do this and that. You are not really supposed to talk about it."

Yet despite a strain of disbelief, even from their own people, Kipp and Momberg believe strongly in taking pride in the old ways. It's a culture that they want passed on to their children, a conviction that it's OK to take pride in who you are and where you came from.

"Now we are taking the best of both worlds," Kipp says. "Before we were always given the worst of both worlds."
Lack of Health Care Makes Parents Sick with Worry

Joann Youngbear knows the pain of the people—she is charged with helping.

Her job as a health coordinator at the Native American Services Agency in Missoula means that every day she sees Indians who need health care but live on their reservations. A single mother herself, she has no health insurance and is ineligible for Medicaid or other benefits because she works.

Youngbear’s 15-year-old daughter Yvette has scoliosis, an unnatural curvature of the spine. While it is not a life-threatening condition, scoliosis causes a nagging ache that gets worse with time, making life increasingly difficult and miserable as victims age.

Youngbear cannot afford to help her daughter. The cost of the brace and physical therapy treatments required is too high for the family’s single income.

“I don’t have the money,” she says. “She was diagnosed five years ago, and she should have had some kind of treatment then. The longer you let it go the worse it gets. It’s hard to know that I can’t help.”

An enrolled member of the Northern Cheyenne tribe, Yvette Youngbear could get the help she needs if she returned to the reservation to live. It’s a choice her mom says is unthinkable for herself or her three children.

“They’ve adjusted to this urban lifestyle now,” she says. “They don’t want to move back there either. It would mean splitting up the family.”

Youngbear and her children are stuck in the losing situation in which many of Montana’s urban Indians find themselves: If they leave the reservation’s chronic lack of jobs behind to seek work and a better life, they lose health care benefits.

More than half of Montana’s Indians live off the reservations, many in urban areas far from the Indian Health Service clinics on reservations. The IHS set up a system of urban health centers in an effort to solve the problem, but only 1 to 2 percent of the IHS budget goes to them, meaning most urban Indians don’t get the care they need.

Urban Indian center health care budgets are woefully inadequate at meeting the needs of urban Indians. About 550 people came to the Missoula center seeking medical help last year, yet its budget for medical assistance is only $295 per month. Only $300 a month is available to cover the cost of prescription drugs.

“The hardest part of our job is deciding who gets the care,” Debbie Tatsey, Youngbear’s partner at NASA in Missoula, says. “We can’t help everybody because we don’t have the money. If somebody needs a $90 prescription, it blows almost a third of our monthly budget.”

Linda Moreno, health coordinator at the Great Falls center, says she tries to help everyone who walks in the door, even though the center is strapped for money.

“We’ll see people as long as we know they have some Indian blood in them,” she says. “We’ll refer them to another facility and try to find care for them if they don’t qualify as Indians.”

She says the situation troubles her and she sees no relief.

“The urban health centers need more money,” she says. “We need to take care of the people that are falling through the cracks.”

Once Indians leave the reservation, their eligibility for contract care lasts six months.

After that, they are on their own. They can return to the reservations for the basic care provided at the clinics, or get limited care at the urban centers, but they are not covered if they seek care from private physicians. Only by returning to the reservation and living there for 30 days are they once again eligible for IHS contract care, an option that most Indians avoid because it would mean splitting up a family or giving up a job.

Donna Standing Rock of Missoula found herself in that situation. She learned last spring that her 13-year-old son, Trevor, had a kidney that wasn’t working well. The thousands of dollars for tests performed to pinpoint the problem were just the beginning of the bills she faced because Trevor needed surgery to repair or remove the kidney. That procedure set her back about $15,000.

Trevor called his situation “scary.” But for his mother, the specter of paying such bills was more than scary. It seemed impossible. Medicaid would pay anything over $305 a month, but for a single mother of four, $305 per month seems beyond her reach.

“When you live from check to check you really don’t figure that in,” she says. “What do you do? I can’t afford $300 a month.

“This is the first real bind I’ve been in.”

Standing Rock had two other options, but both would have meant a return to a life she worked hard to leave behind. If she cut her hours at work to be eligible for full Medicaid benefits, it would return her to a life of dependence on welfare programs, a regression she dreaded.

Standing Rock is proud of her self-sufficiency, something she worked hard for after a divorce and a move to Missoula from Montana’s Rocky Boy’s Reservation six years ago. Through job training programs, she got the education she needed to land a job at Planned Parenthood and get off of Aid to Families with Dependent Children.

“Having a job and independence. Her other option was to send Trevor to Rocky Boy’s to live with grandparents and enroll in school there, making him eligible for IHS contract care. As Joann Youngbear, Standing Rock wouldn’t do that because it would have split apart her family.

With the aid of friends, she found help from a combination of public and private agencies. Trevor had the surgery in June and is recovering well.
Montana’s landless Indians trace their history to the French fur traders who pushed their way west from Quebec. The French encouraged their men to marry Indian women, and a new culture was formed as children were born of Chippewa, Cree and French blood. The English and Americans called them “half-breeds,” but the people prefer the less scornful name “Metis,” French for “mixed-blood.” Metis is also more accurate, as many of them are not half of any race.

The Metis hunted buffalo for subsistence as their Indian ancestors had. Gradually following the buffalo west, many Metis settled in Montana. The people were scattered when the U.S. government began pushing for a treaty with the Pembina Chippewa band, most of whom were relatives of the Metis. The Metis were represented at a treaty conference in 1863, and together the Chippewa claimed 9.5 million acres in North Dakota. However, the treaty was never ratified, and the land was opened to white settlers in 1882.

When a formal treaty was finally ratified, Chief Little Shell and his band were hunting in Montana and were excluded, as were most Metis. The Chippewa and Metis who signed the “10-cent treaty” gave up the 9.5 million acres for $1 million called the Turtle Mountain tribe, they were left with a reservation in northern North Dakota of only 12 square miles.

Little Shell’s people got nothing. With no land to call their own, they spread out across Montana. Those who could prove ancestry in the Turtle Mountain Tribe, but were unable to get land on the reservation, could file for homesteads on public land. Many tried, but met the question that still haunts them today—who is and who is not a Turtle Mountain Indian?

The descendants of Little Shell’s band and many Metis continue the fight for federal recognition. To receive health care they must prove they are direct descendants of an enrolled member of a tribe. Even with such proof, however, unrecognized Indians still have a hard time getting the care they need.

Bob La Salle and grandson Beau are both of Little Shell descent—one of the “landless” tribes in Montana. La Salle has health insurance through employment benefits, but not everyone does.
Steven Weigand's scars are both physical and emotional.

Some Montana Indians have no reservation. Neither do they have the health care guaranteed reservation Indians

**LANDLESS INDIANS ENDURE NEVER-ENDING HARDSHIPS**

Edgar and Tommy Weigand of Chinook and Harlem found out how inadequate health benefits are for landless Indians when their son Steven broke his collarbone three years ago. Edgar is Little Shell Chippewa, Tommy is white. Because Edgar's ancestors were members of the Turtle Mountain tribe, he and his sons can get the basic medical care provided by the Indian Health Service on the reservations. Steven was treated at the Fort Belknap Reservation clinic, where a doctor set the bone and put his arm in a sling.

For Steven, though, the pain was just beginning. Two weeks after he returned to school, a schoolmate grabbed him in the lunch line, taunted him about his mixed race and twisted his shoulders. This time the break was severe; the bone had pierced the skin, necessitating surgery.

The Fort Belknap IHS clinic was unable to help Steven because of the severity of the second injury, and he was referred to the hospital in Havre. Because landless Indians are entitled to only basic medical care, any medical procedures done away from the reservation are at their own expense. Complications during Steven's operation drove up the cost.

"Steven had an allergic reaction to some medication," Tommy Weigand says. "He almost died there. We could have lost him because of a broken collarbone."

The family was left with a $5,000 bill for Steven's surgery. But the financial and racial problems were not over.

The family says Steven was attacked by youths on the streets of Chinook two months later, and the collarbone was broken for a third time. Again, surgery in Havre. This time the operation went smoothly, but the bone needed to be wired together, and another $4,000 was added to the Weigands' medical bill.

Steven had encountered the prejudice that haunts the Little Shell Tribe: Not white, not Indian, they are welcome in neither culture. Steven says the other boys attacked him because of his race.

"That's one of the reasons I moved to Harlem," Tommy Weigand says. "The prejudice is so strong in Chinook. The kids there wouldn't let my boys alone."

His mother now schools Steven at home because she fears for his safety in public schools. The family is still struggling to pay off the debt that was caused in part by prejudice and the unjust treaty at Turtle Mountain in 1904.

The IHS is a "payer of last resort" for enrolled tribal members who need care unavailable on the reservations, meaning that IHS will pay only when Medicaid, Medicare, private insurance or other programs don't cover the cost. Its purpose is to guarantee Indians the care they need, a guarantee that means little to unrecognized tribes like the Little Shell.

"Indian health care is very frustrating," Tommy Weigand says. "Our kids aren't all Indian, but they'd be taken care of if we were recognized. It's not fair."

Velma Flansburg, 69, is a Little Shell, and her late husband was an enrolled member of the Gros Ventre Tribe on the Fort Belknap Reservation. About nine years ago she noticed a lump in one of her breasts and sought help at the reservation clinic. They were unable to do a mammogram, so a tribal officer tried to get her contract care off the reservation.

No one told Flansburg that she was not eligible for contract care, and a year went by without word from the tribe. Flansburg finally had a mammogram done on her own. A tumor was detected and she had an immediate mastectomy, an operation in which the entire breast is removed. Early detection may have meant removal of only the cancerous tumor rather than the breast.

"I wasn't that concerned about it because the doctors weren't," Flansburg says. "If I had known earlier maybe I could have done something."

Flansburg's medical costs were eventually covered by Medicaid and local charities, but she said it was no compensation for the damage that confusion over Indian health benefits caused her.

There are other landless Indians in Montana besides the Little Shell Tribe, and a large part of their life is, like the Little Shell, trying to prove their legitimacy as Indians so they can get the benefits they feel they deserve.

Babe Gopher, 83, is a landless Indian from Great Falls and a member of the Bear Claw Tribe, a group of Chipwewa-Cree trying to gain recognition. They are descendants of Chief Bear Claw, an uncle to Chief Rocky Boy for whom a Montana reservation is named.

She grew up on "Hill 57" outside of Great Falls, an impoverished area where many landless Indians settled while trying to eke out a living. For decades Hill 57, so called because of a Heinz 57 sauce advertisement etched into the hillside, was a symbol of the injustices suffered by the landless people. Most of the residents of the hill have died or moved on or up, leaving a jumble of burned shacks, outhouses and memories behind.

"There was a lot of history handed down to me about the suffering and pain I would endure because I didn't have that piece of paper," Gopher says through an interpreter. "It was a warning from my elders."

A healthy elder, Babe Gopher never saw the need to seek any health care beyond her traditional herbal remedies and spiritual beliefs, but she says many of her 60-odd grandchildren and great-grandchildren have no health or education benefits because their people are not recognized by the government.

"Our people have seen a lot of pain, a lot of suffering," she says. "I don't want to see my grandkids grow up like that."
As a drug education coordinator, Not Afraid is on the road constantly. At Hays High School on the Fort Belknap Reservation, he speaks about substance abuse and the value of self-esteem.

Leroy Not Afraid takes his message to Montana schools:

**Drugs will Destroy your Life**

W hen Leroy Not Afraid looks at a crowd of young faces, he can see the kids who know where he has been.

“They’re out there,” Not Afraid says. As he speaks at a school assembly he singles them out even as he says, “I don’t mean to point anyone out to make them feel bad.”

He wants them to feel good and usually can do so with nothing more than a few songs and jokes, before he hammers home his message: “Drugs and alcohol will destroy your life.” He repeats it several times.

Not Afraid, 21, now the drug education coordinator for Crow Tribal Health, has been carrying this message since he was a teenager and decided to take control of his life and stop fleeing. On weekdays, he visits groups in Wyola, Pretty Eagle, Lodge Grass or Pryor. On weekends he travels around the state speaking at schools or working with administrators in developing prevention programs. His May calendar was jammed with graduation speeches.

When Not Afraid looks at a crowd of young faces, he can see the kids who know where he has been.

“Your older cousins always had the marijuana,” Not Afraid says. “That’s how I got into it.”

So Not Afraid joined a team that won every time, in stealing, bullying, and “huffing.” Together, they tried to break free through a bottle of nail polish stolen from a teacher’s purse, or through the distilled liquid poured from a punctured aerosol can.

“That was jammed with graduation speeches,” Not Afraid says. “It’s easy to get. It was always easy to get. The alcohol is harder to get.”

When he hears children in his groups bragging about the latest exploits of their older relatives, Not Afraid sets them straight with a personal account of the way addiction really is.

“I can speak to them on a level where they can understand,” Not Afraid says. “I can say, ‘Hey, I was there with your older cousin, and I know it wasn’t that way.”

Tim Peterson, the principal at Hays-Lodgepole school at Fort Belknap, says only someone as young and as direct as Not Afraid can reach the students.

“With Leroy Not Afraid,” Peterson says after Not Afraid’s speech, “If it had been someone much older, there would have

For most Montanans, the isolation of the state’s Indian reservations makes it easy to forget about the ravages of drug and alcohol abuse among the state’s Native Americans. It is not unique to the state’s Indian population, but it is decidedly more pervasive. In deaths from cirrhosis alone, Montana Indians perish at a rate 3.6 times greater than the rest of the state’s population. Among those in the 35- to 44-year-old age group, the Indian death rate is eight times the rate for whites.

Leroy Not Afraid won’t forget the way life was for him, though for years it was forgetting that drove him to substance abuse. He wanted to forget the brutal breakup of his parents, who left him with his grandparents at the age of 3. He says his mother was an alcoholic, but is reluctant to blame her for the Fetal Alcohol Effects (FAE) that has left his 13-year-old brother with an attention deficiency.

“He used to get really violent, and you couldn’t do anything to stop him,” Not Afraid says to a friend from when he was 14 so he could make enough money for a good-size bag of marijuana and a few sheets of acid.

“Your older cousins always had the marijuana,” Not Afraid says. “That’s how I got into it.”

Young is relative to Not Afraid, who was stealing guns when he was 14 so he could make enough money for a good-size bag of marijuana and a few sheets of acid.

“Your older cousins always had the marijuana,” Not Afraid says. “It’s easy to get. It was always easy to get. The alcohol is harder to get.”

The Crow is a dry reservation, but alcohol can be had in Hardin, on the reservation’s northern border, or just across the state’s southern border in Wyoming. Not Afraid says alcohol wasn’t, and isn’t, as profitable as the fringe drugs. “Everyone is not going to have alcohol all the time because they’re not going to make money off of it.”

Some of the same dealers continue to work the streets of the reservation, and they chide Not Afraid when he walks by, straightener now and full of confidence. He carries himself with the same poise when he sees some of his old “bros,” the ones he left behind in 1986 when the FBI came to his house looking for stolen guns and Not Afraid made the decision to change his life.

“They respect me for what I’m doing,” Not Afraid says. “I never ever try to put myself on a higher level. They were my buds; I loved ’em. I did.”

Not Afraid says that after he quit, his circle of friends moved along the cycle of addiction to cocaine and heroin. One was shot to death during a drug deal. Another wandered in front of a truck.

“One is in Warm Springs after losing his mind from using White Out. He really don’t know who he is anymore,” Not Afraid says, reluctant to speak the names of the dead and the sick because of what he has learned about respecting kindred Crow spirits.

These memories give his message resonance. When he hears children in his groups bragging about the latest exploits of their older relatives, Not Afraid sets them straight with a personal account of the way addiction really is.

“I can speak to them on a level where they can understand,” Not Afraid says. “I can say, ‘Hey, I was there with your older cousin, and I know it wasn’t that way.”

Tim Peterson, the principal at Hays-Lodgepole school at Fort Belknap, says only someone as young and as direct as Not Afraid can reach the students.

“To speak to a group of kids for an hour and a half, it is difficult to keep their attention for that long,” Peterson says after Not Afraid’s speech. “If it had been someone much older, there would have

As a drug education coordinator, Not Afraid is on the road constantly. At Hays High School on the Fort Belknap Reservation, he speaks about substance abuse and the value of self-esteem.
A Health Crisis

Not Afraid prays before he gives one of his talks. Afterward he talks to a student and then enjoys a game of shuffle puck with teens at a community center.

been problems.

A school counselor says what makes Not Afraid stand out is the lack of American Indians who give speeches. He is one of a half dozen young adults who do so, and he'll tell you he's the best.

On a rare break, Not Afraid shoots hoops with an ad hoc team of relatives and friends who compete shouting game plans in Crow to confuse opponents. After the game, Not Afraid may go out to the bars with his teammates, but he sits in the car with his younger cousin while everyone else goes inside.

“It gets hard sometimes constantly being a role model,” Not Afraid says, recalling a time when he was following a group of his cousins from bar to bar acting as designated driver. A girl from one of his groups came up to him and pointed her finger: “You’re Not Afraid, Not Afraid! What are you doing here?” Not Afraid just threw it right back, “I told her that I was there to help make sure my cousins made it home alive, and then I asked her how old she was, to let her know that she was in violation of the law.” “They always try to tear you down,” Not Afraid says, and when they do, he finds strength in his evangelical Christian beliefs, which have been a constant force holding Not Afraid together since he abandoned the temple of the drug.

“I’m glad that I was brought up to believe that there’s something greater than me, because if I hadn’t had that I would have went crazy,” Not Afraid says. But he never imparts that sense to the kids he teaches. Even when he reaches a point in his speech or in his counseling when he feels the need to bring in his religion, he can’t.

Reservation educators are allowed to use “traditional prayers and ceremonies and to do cedar and sweet grass and they even bring the medicine man in,” Not Afraid says with a hint of bitterness. “But if I say ‘Jesus Christ’ I’ll get kicked right out of there.”

Not Afraid does use the traditional methods in his counseling. In the talking circle, he passes around a rock that allows the holder to release his emotions. He heard about the circle helping at the Alkali Lake Reservation in Canada, which had an alcoholism rate of nearly 100 percent a few years ago.

But most of what he teaches comes from what he has learned the hard way. And he’s resolute in his goal of turning kids away from the hard life he lived.

“They’re out there,” Not Afraid says. “And I’ll find them because I’ve been there too.”

In deaths from cirrhosis alone, Montana Indians perish at a rate 3.6 times greater than the rest of the state’s population.

Text by Bill Heisel
Photos by Kort Duce
Not Afraid, the drug education coordinator for Crow Tribal Health, has been carrying the message that drugs and alcohol will destroy lives since he was a teenager and found himself on a path of destruction.

Not Afraid spends much time on the road. He grabs sleep when he can, often staying at homes instead of a motel. And although he likes to speak spontaneously, he often spends hours preparing his speech outline. He drinks a soda and works on this speech until after 2 a.m. before resting.
Brandon Moreno received a blood transfusion after an accident.
But that life-saving blood was infected.
And from that day on his life was forever changed.

**LIVING IN THE SHADOW OF AIDS**

Moreno was in a car with his half-sister Kala Jones and their grandmother when it careened out of control, flipped 13 times and came to rest upright in front of their home on the Northern Cheyenne Reservation.
Ambulances sped 14 miles down Muddy Creek Road to collect the victims, who were later flown to St. Vincent Hospital in Billings.
Moreno's grandmother died that night. But Moreno and Jones, both of whom lost a lot of blood, struggled to make a complete recovery. They grieved for the loss of their beloved grandmother, but as their pain began to recede and their scars began to heal, their nightmare seemed behind them.

Six years later the accident came back to haunt the family. This new blow they suffered hit with as much intensity as the news that was delivered that late September eve when their grandmother's spirit left them.
Moreno had contracted the HIV virus from the blood transfusion needed to treat his injuries.

Their mother, Marti Quirk, had read a magazine article about AIDS and decided to get tested at the Lame Deer Clinic. Her test result was negative, but just to be safe, she sent Moreno and Jones to the clinic to also get the test.
Quirk remembers the day the results came back.
"They called me at work and said, 'You gotta come down. One of your tests came back positive.'"
It was Moreno's. His mother and sister were weeping when they told him.
"I said, 'Bulls**hit' I was denying it," recalls Moreno, then 16 years old.
Acquired immunodeficiency syndrome (AIDS) is caused by HIV, or human immunodeficiency virus. HIV weakens part of the body's immune system and leaves it open to life-threatening infections.
HIV is carried in body fluids and can be transmitted through sexual contact or through sharing of blood or blood products.
Through the end of 1990, nine Native Americans in Montana had developed AIDS. While the raw numbers are not great, it represents 16 percent of all reported AIDS cases in the state, among a population that makes up only 6 percent of the state's total populace.

Moreno has not developed full-blown AIDS, and with the confidence of youth declares his belief he'll be cured one day.
Dr. Chris Lantz, family practitioner at Lame Deer Clinic, has prescribed AZT for Moreno, a drug that shows some promise in staving off the infections that visit patients so frequently and can prove fatal in a flash. It was Dr. Lantz who narrowed Moreno's sources of infection to the blood transfusion he received at St. Vincent that night. He says hospitals had not yet begun testing for tainted blood when Moreno was transfused.

The chilling news changed Moreno's relationship with his family, his friends and the people in Lame Deer.
Moreno says his mother nags him continually to take the AZT.
"She's always saying, 'Take it, you might live longer."
"I hate that pity thing people put on me," Moreno says.
And while Moreno, who says he keeps up on new information on AIDS research, is optimistic about his health, Quirk is more fatalistic.

"I feel pity, I feel loss," she says as she nervously sucks on a cigarette, having recently resumed her smoking habit. When she talks about Moreno's future her eyes suddenly fill with tears and her face softens. "He won't get to know what love is like," Quirk says.

Moreno, sitting in their living room watching her, frowns and looks away.

Jones admits to frequent fights with Moreno. And she won't share cigarettes or drinks with him anymore.

"I might have sores in my mouth and you could get it [an infection] that way," Jones tells him in her defense. On the other hand she has no problem letting him babysit her 18-month-old daughter, Tina.

She admits it was she who told others in Lame Deer when Moreno tested positive. "I was kind of freaked out," Jones says. "I was kind of a blabber mouth then."

In a town with a population of about 2,000, it didn't take long for the word to spread. People began to shun him, Moreno says.

Moreno's best friend is Joe Brown. They play basketball together for hours at a time. They play rough. So when Brown heard the rumors he decided to confront him.

"We started walking and talking and played basketball," Brown recalls as he recounts his emotions.

"I just felt like there was something wrong with that day," he says, but he told himself "nothing would happen to us because we live on the reservation." He made himself come right out and ask, and Moreno didn't hesitate to tell him it was true.

And this tough boy who hadn't cried since he can remember, wept that day. "I felt like he was my brother," Brown says. "It seemed like one of my family members got it."

Brown admits that he was also frightened. "I was like my dad at first," he says, telling of how his father tried to stop him from seeing Moreno. "But I wanted to help him through it."

It wasn't easy. Because many people consider AIDS a "homosexual" disease, folks in town began whispering that Moreno was gay. Brown has known Moreno since sixth grade and snorts, "I KNEW he wasn't gay."

John Brown, Joe's father, explains he feels some precautions are prudent and talks about the general attitude on the reservation. "We're extended families," Brown says. "What we have we share." So it was only natural when one of his daughters tried to share a chicken leg with Moreno. Brown stopped her.

"It's just the idea," he says about the possibility of infection. "I'm afraid there's always a chance."

He also cites an incident during a casual game of touch football Moreno and other boys were playing outdoors one day. One boy accidentally jammed his thumb in Moreno's mouth.

"Out of innocent play it could be passed on," Brown says.

So while Moreno and Joe Brown still play basketball together, "we quit rough housing," Joe says, then adds with emphasis: "I'm still his friend, no matter what."

From his association with Moreno he feels "people are realizing you can have a friend with AIDS, as long as you're careful."

Dr. Lantz wants it known that the risk from casual contact with an infected person "is next to zero."

"You can be close, you can be friends, you can give hugs," he says.

Now Moreno channels his energy toward his dog, Bolo. He grabs Bolo's ears and jumps with him. He ruffles the rough fur and doesn't hold back the contact he has had to give up with humans. Bolo revels in the attention and jumps higher and runs faster at the urging of his master.

By his own admittance, Moreno has a limited life on the reservation and he talks about moving to Oregon where
Talking about disease would scare students, principal says

Brandon Moreno dropped out of Colstrip High School last year. But he wanted to return this fall to share an important message.

He wants to talk to other teenagers about his HIV.

Principal Carol Wicker agrees he should talk about it but says he needs to share it elsewhere.

"I've told him, 'You cannot be a prophet in your own land,'" she says. Moreno first asked his health teacher, Joe Sukut, for permission to talk to the class about his disease. Sukut sent him to Wicker for the OK.

Sukut admits that Moreno's request took him by surprise. "I was shocked that one of my students had it," he says. "Especially in rural Montana, we're so isolated from a lot of these things."

But Wicker refused him permission, citing Colstrip schools' policy of protecting the confidentiality of infected students.

The policy, developed in 1988, states that the identity of a student infected with any communicable disease (including AIDS) will be revealed only to people who need to know, such as the school nurse.

Wicker says it does not matter that Moreno isn't choosing to keep his illness a secret. The policy is also designed to keep paranoia to a minimum in the school, she says.

"I don't believe students realize the full ramifications of exposing themselves by talking about their illnesses," she adds. "She believes students might not be as willing to accept the information as Moreno would be to reveal it. What was meant as a sincere gesture could be greeted with rejection of the worst kind, she says.

"It's built to prevent panic and to protect the instructional atmosphere by making sure students are not more upset than necessary," she says. "It's my job to anticipate what may happen."

Colstrip High School began teaching sex education more than seven years ago, says Sukut. The school also has an AIDS education program and Wicker says that the curriculum reflects that. For example, senior paper topics include AIDS and even the math program uses multiplication problems related to AIDS research.

She points to the education program as one reason she says people are accepting Moreno. Instead of being afraid of him, she says, "they wanted to take care of him. I think that is a result of the education."

"You can still say, 'I love you,' but if you say that with your hands behind your back, they'll never believe you." Sukut says that with some training, Moreno could go on the road with his message. But he agrees with Wicker that Colstrip High School is not the place to do it.

One of Moreno's teachers at Colstrip believes his openness about his illness has already triggered a new awareness of AIDS in the school and the community.

"It's prepared Colstrip to deal with the next patient," says Gisela Schneider, the school's art teacher.

Schneider believes the school is doing a good job with AIDS education. "They're hearing good information that is accurate and clear," she says.

On a personal level, Schneider is trying to encourage Moreno to use what she says are his exceptional talents as an artist and writer.

"He could make a career out of his visual abilities," she says with admiration.

She has encouraged Moreno to finish high school and attend art school in Colorado.

But for now, Moreno's goal is not so far-reaching. He had hoped to finish school but has moved to Oregon and put that goal on hold. Mostly, he wants people to understand.

He's written an article he hopes to have published. He tells what it's like to live with HIV.

"After all I am like you in every small way except my H.I.V.," he wrote.

It is signed: "By a student you all know and reject so well. Brandon."
Inside are stories about many of the health issues that affect Montana's Indians. There are many problems, but the tribes are also working towards solutions. They are trying to train more native health care professionals like Dr. Michael Dempsey. Teenagers like Kristal Davis can stay in school and excel while still tending to their babies.

Those of us who were born in Montana call ourselves natives. Our fathers were born here. Maybe even our grandfathers. We grew up in the state that we loved, camping, hiking, fishing, hunting.

But we weren't the first natives. The first natives were several tribes of Indians who moved in and out of the area, hunting, fishing, coexisting with the land. Almost 48,000 Native Americans live in Montana today. Yet today there is little understanding by Montana's other 750,000 residents of Indian history, culture and issues.

The School of Journalism at the University of Montana has in recent years been trying to integrate into its curriculum courses that include information on Montana's Indians. It has had an active recruitment program for Native American journalism students. The Montana Kaimin produced a “Native News Page" and speeches and workshops have featured Native American journalists. The past two years the School has had an honors course that examines critical Montana Indian issues. Last year reporters and photographers, Native Americans and whites, combined forces to explore education issues.

This year, students have been covering Native American health issues. This special report is the result of more than six months of work by students and faculty.

We're confident this project helped students better understand a critical issue for Montana's Indians. We hope it will help all Montanans also understand.

Thanks to the Missoulian and the Billings Gazette for publishing and distributing this special section.